Community Service Network 7 Meeting
DHHS Offices, Biddeford
January 26, 2007

Approved Minutes

Members Present:

- Anita Jones, Community Mediation Services
- Jennifer Goodwin, CSI
- Scott Ferris, Creative Work Systems
- WC Martin, Common Connection Club & TPG
- Mark Jackson, Harmony Center & TPG
- David Proffitt, Riverview Psychiatric Center
- Elizabeth Sjulander, Saco River Health Services
- Chris Souther, Shalom House
- Rita Soulard, SMMC
- Larry Plant, SMMC
- Mary Jane Krebs, Spring Harbor
- Jen Ouelette, York County Shelters
- Meg Gendron, York County Shelters
- Deborah Erickson-Irons, York Hospital

Members Absent:

- Karl Wulf, Common Connection Club
- Jeanne Mirisola, NAMI-ME Families (excused)
- Center for Life Enrichment (vacant)
- Goodall Hospital
- Job Placement Services, Inc.
- Donna Ruble, Sweetser
- Kelli Star Fox, Transitions Counseling (excused)
- Volunteers of America

Staff Present: DHHS/OAMHS: Ron Welch, Don Chamberlain, Carlton Lewis. Muskie School: Janice Daley, Sherrie Winton.

Agenda Item	Presentation, Discussion, Questions
I. Welcome and Introductions	Carlton opened the meeting and participants introduced themselves.
II. Review and Approval of Minutes	Unanimously approved.
III. Meeting Schedule	Carlton referred participants to the CSN meeting schedule, noting that this CSN meets on the 2nd Thursday of the month.
IV. CSN Participation	Don Chamberlain explained that there are three documents that went out: 1. Contract Amendments for adult mental health service contracts (about 88% came back) 2. Provider agreement (MaineCare): (Only 23% came back) 3. MOU: 50% were returned Don listed those who still need to submit this material.
V. Budget and Legislative Update	**Supplemental Budget** Because managed care did not happen and the $10.4M anticipated savings will not be realized, that amount has been submitted in the Governor's supplemental budget, pending passage by the legislature. **Biennial Budget (07-08, 08-09) Issues** • Administrative Services Organization (ASO): An ASO will perform (if approved by the Legislature) the following administrative services: 1) enrollment, 2) prior authorization for some services, and 3) utilization review for some services. The ASO would contract with the Department, not providers, to receive payment for these administrative services with no risk assumed by the ASO. First-year Department-wide savings to be $5M, second year $6.5M. These savings come from Maine Care seed funds, resulting in a $2 Federal match loss for every $1 MaineCare saves (does not spend). The total biennial budget impact, therefore, is $15M for the first year and $19.5 for the second year.

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	• Rate standardization--community support services: Meetings are underway (with DHHS and members of the Maine Association of Mental Health Services) to determine standardized rates for certain community support services. (Historically, providers have individually negotiated rates with DHHS, which accounts for the current variety of rates.) The rate standardization must result in a savings of $10M in each year of the biennial budget ($4M from adult, $4M from children's, $2M from "MAP" private practitioners). The savings will come back to the Department for reinvestment in community programs, and CSNs will have opportunities to discuss and make recommendations on the reinvestments. The savings are MaineCare seed funds, so the Federal match loss (described above) applies. • Reassignment of ICM positions: If the legislature passes the proposed budget, 30 positions now held by OAMHS Intensive Case Managers (ICMs), will be transferred through attrition (retirement, job changes, etc.) to the Office of Integration Access and Support (OIAS). The OIAS, which handles Temporary Assistance to Needy Families (TANF), food stamps, etc., is seriously understaffed and under Federal scrutiny for delays. As ICM vacancies do occur, OAMHS may relocate remaining positions to best cover service needs. Other legislation updates: • Amend the current statute that establishes CSNs as local service networks and redefine CSNs with the charge of the consent decree requirements plan. • 2nd bill: Address the issues relating to involuntary commitment at state hospitals. There may be more added to this bill relating to confidentiality, especially for people with mental illness in jails. **ACTION:** OAMHS to send out legislation to CSN members when available.
VI. Review Data on Contract Performance and Consent Decree Requirements	Contract reviews conducted so far revealed the following themes: • Notifying consumers and families of NAMI-ME services: Though most agencies report they do inform consumers of these services, most do not have actual written policies and procedures in place. • 24/7 access to records: Some providers already do it, some in the process, and some not at all. • Community support workers at treatment and discharge meetings: Agencies report that they attend when they know, but note difficulties/breakdown in communication regarding hospitalizations. OAMHS will be working with crisis providers, community support agencies, and hospitals to improve communication for better continuity of care. • Mechanism needed for consistent reporting on compliance with requirement that community support service providers meet with consumers within 4 days of discharge from inpatient care.
VII. Policy Directive from OAMHS regarding information sharing	Still under review in the Attorney General's Office.
VIII. Resolve PL 192	Resolve PL 192 directs DHHS and the four IMD's (Institutes of Mental Disease), Riverview, Dorothea Dix, Acadia, and Spring Harbor, to work together on a 3-step process to draft a strategic plan to improve quality and access of hospital based mental health services. Community hospitals with psychiatric units have also been involved in the development of the plan, as the Resolve requires, and consumers and providers will have an opportunity to comment on the interim draft report, due for release to the public soon. Stakeholder forums will be held as follows, after which DHHS will compile a final draft for presentation to the Legislature by March 15: Feb 5: Riverview, 9-12 Feb 21: Dorothea Dix, 1 pm March 1: Spring Harbor, 2-3:30 pm **ACTION:** OAMHS will send draft report to CSN members when released to the public.

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IX. Crisis Services	Don Chamberlain reviewed his memo on Crisis Services, which includes actions required by the Consent Decree Plan for Crisis Stabilization Units and Observation Beds, and definitions for crisis stabilization services. Statewide, county, and CSN-wide crisis bed data also provided (this info will be updated to reflect information received at CSN meetings, increasing number of beds): • 48 crisis beds statewide • 7 crisis beds located in CSN 7 • 84% utilization rate **Summary of Questions/Comments/Concerns:** • There were some questions about the meaning of utilization rate and how the bed is held. • Explore how many days a person could not get into a bed because it was full. • Could open beds be posted with Maine Hospital Association? (This may be an issue as the status of open beds is always changing**).** • There were also questions about per diem rate and if it was driven by salary. For instance, Ingraham's rate is lower than some others, but they have a doctor who does rounds everyday, so salary may not be included in their daily rate? **Counseling Services Inc (CSI) Crisis Stabilization Unit (CSU)** Jennifer Goodwin of CSI presented data and described their CSU: • The Biddeford/Saco area has the highest number of admissions. • The average length of stay is 4 days. • Most people discharge to their homes. • There is a kitchen, a common space, two private meeting spaces where meds and sharp knives are kept, a communal room. Food is cooked by staff with participation of consumers. • There is nursing staff who are there until midnight. • Referrals come from clients, CSI clinicians, physicians, hospitals—emergency departments. • It's a billable service and there is a fee. • Services can be available to those with no money, but if a person can pay, that option will be exhausted first. • They do take people with a suicidal ideation and with a suicidal plan, after discussion of person's ability to be safe in the facility. Questions/Suggestions: • Explore data: Reasons why people come into treatment • Bring data on referrals • Are there more transfers to hospitals/why? (Also, in what circumstances are people sent to the hospital because they may be better served there). • Bring data next time showing the trends of where people are discharged to, their diagnosis, etc. • Do individuals keep coming back until they are ready for treatment? What is the re-admit rate? **Spring Harbor Observation Beds (OBs)** Mary Jane Krebs of Spring Harbor presented detailed information about Spring Harbor's OB level of treatment. Highlights from handouts: • Intensive, hospital-based outpatient diagnostic and treatment service, 48-hour maximum stay • Averted hospitalization for 39% of OB patients • Average stay: 1.8 days, Average beds per day: 3

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87% referrals from hospital Emergency Departments (75% from MMC)
8% patients from York County

Questions/Suggestions:

Are observation beds insurance only? (They are MaineCare, uninsured, and Medicaid.)
Compare the stay of a person in the hospital from outpatient to one that went through the observation bed and then hospitalized. Was it a shorter stay? (This information is being gathered.)
A question was asked about where elders go. Mary Jane explained that most of the elders are admitted to the “P6” unit at Maine Medical Center because they have medical issues as well as mental health issues.

Don reported that several other useful data categories for crisis stabilization have been identified in this round of CSN meetings.
ACTION: OAMHS will compile these additional data requests and send out to all crisis providers and provide the results for the February meetings, where possible.
ACTION: Members will make recommendations around crisis stabilization services in CSN 7 at the February meeting.
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<tr><td>X. Statewide Policy Council</td><td>
Ron Welch described the selection process for the Statewide Policy Council. The Council will consist of 15 members representing various service and geographic areas. Volunteers and nominations are to be submitted to Elaine Ecker at the Muskie School, eecker@usm.maine.edu by February 1 (deadline later extended to February 9). OAMHS will then select the representatives and meetings will begin in March.

ACTION: OAMHS will select representatives to the Council, notify all CSN members, and convene meetings in March.
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<tr><td>XI. Adequate geographical coverage and resource gaps</td><td>
Members received a chart showing Maine’s population and the numbers of people with Serious Mental Illness (SMI), broken down by counties and CSN. The numbers are based on the 2000 US Census and the 5.4% rate the federal government uses to establish the number of adults (18 years and over) with an SMI. Using these calculations:

52,579 adults in Maine with SMI.
7,585 in CSN 7 (York).

Another handout described the ongoing process for reviewing resources and the eight core services in order to identify gaps in coverage. At each monthly CSN meeting, one or more of the core services will be reviewed, with OAMHS providing information around population numbers, service locations, types, and providers, funding, utilization, and any other pertinent data, as appropriate and available. At the following monthly meeting, OAMHS will ask for recommendations from the CSNs and will use those recommendations to inform allocation development, budget requests, and changes/additions to the service array.

Schedule:
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<tr><td>Month</td><td>Service</td><td>Month</td><td>Service</td></tr>
<tr><td>January</td><td>Crisis Stabilization, Peer Services</td><td>May</td><td>Residential Services</td></tr>
<tr><td>February</td><td>Other Crisis Services</td><td>June</td><td>Vocational Services</td></tr>
<tr><td>March</td><td>Community Support Services (ACT, ICI, CI)</td><td>July</td><td>Inpatient Services</td></tr>
<tr><td>April</td><td>Outpatient, Medication Management</td><td></td><td></td></tr>
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Review of Peer Services
In York county: $235,848 dollars were spent on an annual basis on peer centers and social clubs. If we use that population of adults living with severe mental illness, it breaks down to $30 per person. Peer support service funding ranges from $9 (CSN 2) to
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Agenda Item	Presentation, Discussion, Questions
	$50 (CSN 6). Questions/Suggestions: • Consider utilization rates of services and costs • Consider how the rate responds to population density. • How do funds get re-distributed once utilization is looked at, the number of services, quality outcome data, etc? Several suggestions included coordinate billing, projection and funding and having a systematic way to understand quality outcomes. (Leticia explained that they are working with an evaluator to develop some fidelity measures for peer support). • Does funding get re-distributed from another service area? (Leticia explained that they will be looking at what is equitable, as well as having a preference to go for new money. She mentioned that it's not just about the dollar figure but also considering what kinds of services need to be looked at.) • Consider gathering anecdotal and descriptive data about the low barrier support that is available to people in social clubs, peer centers, etc. • Available services at peer centers in this CSN area were reviewed. • Consider conducting a consumer survey to elicit feedback. • There have been some efforts to bring peer support to SMMC but it has not happened as of yet. It's been very successful at Maine Med and Brunswick. Amistad works with Maine Med and in Brunswick it is Sweetser. **ACTION:** Members will make recommendations around peer services in CSN 7 at the February meeting.
XII. Procedures and Protocols for Inpatient Admissions	David Proffitt gave a brief overview of the procedures and protocols being developed to meet the requirements of the Consent Decree Plan for inpatient admissions to state and specialty hospitals. The intent is to make sure that state beds are maximally used for the purpose intended. Under the new procedures, Spring Harbor Hospital will act as the primary referral source for admission to Riverview. Community hospitals will now contact Spring Harbor, not Riverview directly, when seeking inpatient admission. Though there are exceptions described in the Consent Decree Plan, referrals normally should flow as follows: Crisis providers → Community hospitals → Specialty hospitals (Spring Harbor, Acadia) → State hospitals (Riverview, Dorothea Dix).
XIII. Update on vocational initiatives	Mandatory vocational trainings for Community Support Workers have been scheduled around the state for late February and early March.
XIV. Public Comment	None.
XV. Plan for February meetings	The February 8th meeting will be held as scheduled: 1-4 pm at the DHHS Offices, Biddeford.
XVI. Agenda Items	▫ Peer Services, Part II ▫ Crisis Stabilization Units, Part II ▫ Crisis Services Review ▫ PL 192 Draft Report